OKLAHOMA STATE BOARD OF
MEDICAL LICENSURE & SUPERVISION
P. O. BOX 18256, OKLAHOMA CITY, OK 73154-0256
(405) 962-1400
e-mail: licensing@okmedicalboard.org

Volunteer Practice Setting Information

(Please print or type)

NAME OF PHYSICIAN:_____

Mailing Address: _____

_____

Volunteer Practice Location:_____
Name of Facility

_____
Address

_____ _____ _(_____)_____
City State Zip Code Telephone Number

I hereby certify under oath that in accordance with Title 59 O.S., §493.5, the services being provided at the facility listed above are for the sole treatment of indigent and needy persons or persons in a medically underserved area and the services are being provided without the expectation of receiving any payment or compensation. Additionally, I understand that I may not practice at this facility until authorization from the Board is received; and, if I desire to change facilities that I must obtain prior approval from the Board.

_____
Signature of Physician

Sworn to before me this date:_____

_____
Notary Public

(SEAL)

Commission Number:_____ My commission expires:_____